[illegible] transfusions should not be car- [illegible] the basis of a single amniotic [illegible] ination, as has been done in the Serial examinations at one-week in- [illegible] are more reliable but not infallible [illegible] ing the degree of fetal illness. [illegible] ks of such a procedure to the [illegible] are small. There is a morbidity of 5- [illegible] per cent, usually due to intra- [illegible] cle or psoas muscle injection or [illegible] otic fluid leak. There have been no [illegible] reported as yet, but some severe [illegible] fections have been encountered. [illegible] ances have been made in the technique of the transfusion since introduced. The use of indwelling [illegible] r several days is being explored, [illegible] early to evaluate it.

[illegible] reports on the neurologic status [illegible] vors are quite encouraging, but [illegible] ough data are available to be [illegible] that the survivors will be com- normal.

[illegible] remembered that a high per- [illegible] of these infants are being born pre- ly and that this fact alone predis- them to a higher risk of brain dam- [illegible] mal. In general these infants [illegible] more than the usual number ange transfusions, some having re- as many as eight!

[illegible]

BLEM that has not received suffi- [illegible] tion is the fairly high number of [illegible] have at birth or later devel- [illegible] levels of conjugated serum [illegible]. The suspicion also exists that [illegible] have an increased incidence [illegible] anemia and hernias and that [illegible] disease" may very rarely occur. [illegible] obvious that we have much to learn [illegible] procedure despite the fact that [illegible] n vogue for four and a half We will not learn much, however, [illegible] others with these problems are [illegible] treatment teams that are pre- [illegible] equipped to study the problem. [illegible] ly significant that the two areas [illegible] that lead research in this field, [illegible] and Canada, have medical practices that encourage consoli- [illegible] resources.

physicians still do not share Dr. Crist's understanding of and appreciation for school health, the learning process, and health education as a profession requiring special competences.

Dr. Sears equates sex education, or Family Living Education, with health education; would he also limit medical practice to internal medicine? Dr. Read suggests a three-point plan in which health instructors should consult with a physician on ". . . their proposed health teaching plans" in order "to maintain a balanced program." How many physicians—or teachers—would follow this procedure for long? Why should they? Most physicians wouldn't know good teaching plans from bad ones, any more than the teacher could evaluate a physician's medical prescription. Do these men, as they suggest, really believe that one-shot, school-wide assemblies and/or a series of "expert" program speakers will truly educate people about health matters?

Piecemeal efforts won't do much to upgrade school health education. As Dr. Crist pointed out, "Health education in the public schools is a complex, continuing process. . . . We need to do a better job of hiring true professionals (health educators). . . . And, after we've hired a professional to take on classroom education, we've got to be sure they have a free hand in developing, and then implementing, a well-balanced program in health education."

Universities are trying to supply these professionals by preparing school health educators competent in health science, human behavior, the learning process, and school and public health.

Dr. Crist's comments set forth clearly the logical answer to the question: employ qualified health educators in the schools and provide them with adequate financial and moral support. We agree with Dr. Read and Dr. Sears in their suggestions of cooperation between physicians and educators. Perhaps both groups can work together through local and state professional organizations to implement Dr. Crist's suggestions.

For example, school health education is categorically excluded from qualifying for

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Tobacco Industry Chided

Editor, MEDICAL TRIBUNE:

The response of the tobacco industry to our recent cancer article on tar yields from 56 brands of cigarettes seems entirely disproportionate to the stimulus. Still another tobacco industry official has attacked our interest in the health and well-being of people by attempting to discredit these scientific findings.

James C. Bowling, vice-president, Philip Morris, Inc., has charged that the Roswell Park Memorial Institute studies, as published in one of the nation's leading cancer research journals, were inadequate. He neglects, however, to offer any proof of their inadequacies.

He further notes, "The tobacco industry has established its own 'tar' and nicotine laboratory" but again neglects to provide any comparable data on the "tar" and nicotine levels. We would welcome the opportunity to see the listings of "tar" and nicotine levels from their laboratories.

The reasonableness of our suggesting that smaller doses of "tar" and nicotine would be less dangerous to health has been substantiated repeatedly by clinical observations, epidemiologic studies, and experimental work. We can only conclude that the tobacco industry fears that the public will switch over to low-tar brands or will shun the 100-mm cigarettes which are the focus of the sales effort at present.

Neither I nor my scientific colleagues have any interest in "punishing" the tobacco industry. Since the industry can make and sell a relatively safer product, it is hardly a "punishment" to call upon industry to stop promoting a more hazardous product—one with about twice as much "tar." We also have no wish to crusade against smoking for moral reasons. We are interested only in upholding the medical tradition that major health hazards be eliminated whenever possible.

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